STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175346	A. BUILDING _____ B. WING _____	C 12/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMA MANOR	234 MANOR CIRCLE ALMA, KS 66401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #70944 and 70945.	F 000		
F 273 SS=D	. 483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT A facility must conduct a comprehensive assessment of a resident within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.) This REQUIREMENT is not met as evidenced by: The facility identified a census of 29 residents. Sample size was 4 residents. Based on observation, record review, and staff interview, the facility failed to complete a timely Minimum Data Set 3.0 (MDS) assessment for 2 (#3, #1) residents of the sample as required. Findings included: - Resident #3's face sheet documented the facility admitted the resident on 11/15/13. The History and Physical dated 11/20/13 listed the diagnoses: psychosis/delusion (any major mental disorder characterized by a gross	F 273		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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impairment in reality testing/an untrue persistent belief or perception held by a person although evidenced shows it is untrue), pacemaker (used to regulate the heart), dementia (progressive mental disorder characterized by failing memory, confusion), and agitation.

The nurse's note dated 12/3/13 and timed 5:13 P.M. revealed the facility obtained and order for an emergency discharge from the facility.

The admission MDS with the assessment reference date of 11/22/13 revealed the staff did not complete the MDS until 12/4/13, 19 days after admission to the facility. The facility completed the MDS the day after the resident was discharged from the facility.

On 12/3/13 at 2:30 P.M. staff held onto the resident's arm and assisted him/her from the dining room to the front lobby. The resident walked slowly and took small steps.

Administrative staff A on 12/5/13 at 4:29 P.M. stated the MDS was completed and in the computer.

Administrative staff B on 12/6/13 at 12:09 P.M. acknowledged the staff did not complete the MDS until 12/4/13.

The clinical record lacked evidence the facility completed the admission MDS within the required time frame.

- Resident # 1's face sheet identified the facility admitted the resident on 8/19/13.

The computer diagnoses list included: muscle

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weakness, cerebrovascular accident (CVA- the sudden death of brain cells due to lack of oxygen when the blood flow to the brain is impaired by blockage or ruptures of an artery to the brain), schizophrenia (psychotic disorder characterized by gross distortion of reality , disturbances of language and communication and fragmentation of thought, perception, and emotional reaction), diabetes (when the body cannot use glucose, there is not enough insulin made or the body cannot respond to the insulin), hypertension (increased blood pressure), esophageal reflux (backflow of stomach contents to the esophagus), extrapyramidal disorder (movement disorders as a result of taking certain medications), and abnormal involuntary movement.

The admission MDS with the assessment reference date of 8/27/13 revealed the social service staff completed their section on 10/14/13 and nursing staff completed their sections on 12/5/13. The resident triggered the following Care Area Assessments (CAA): cognition, visual, communication, incontinence, falls, nutrition, feeding tube, dehydration, pressure ulcer, and psychotropic medication. Staff completed the CAAs for cognition, visual, and feeding tube on 12/5/13 but had not completed the remaining CAAS.

The nursing notes dated 11/29/20 at 5:21 P.M. revealed the facility transferred the resident to the hospital at 3:30 P.M. and the resident remained in the hospital as of 12/5/13.

Administrative staff A on 12/5/13 at 4:29 P.M. stated the MDS was completed and in the computer.

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F 273	Continued From page 3 Administrative staff B on 12/6/13 at 12:09 P.M. acknowledged the staff did not complete the MDS until 12/4/13. The clinical record lacked evidence the facility completed the admission MDS within the required time frame.	F 273		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: The facility identified a census of 29 residents. Sample size included 4 residents of which 3 were reviewed for feeding tubes. Based on observation, record review, and staff interview, the facility failed to provide tube feedings as ordered and failed to provide timely notification and assessment for 1 (#1) resident of the sample that required hospitalization in an intensive care unit. Findings included: - Resident #1's admission Minimum Data Set 3.0 reviewed on 12/3/13 with the Assessment Reference Date of 8/27/13 was incomplete. The current care plan dated 8/18/13 revealed an admission care plan with the interventions: fluids	F 309		

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via percutaneous endoscopic gastrostomy (peg) tube (the introduction of a nutrient solution through a surgically inserted tube into the stomach through the abdominal wall) , diuretic orders, labs as ordered, monitor for edema (swelling) and or dyspnea (difficulty breathing), nothing by mouth, HN 2 calorie (supplement), monitor tolerance of feedings, elevate head of bed 30-45 degrees, weekly weight monitoring program, oral hygiene every shift, and observe peg tube site for signs and symptoms of infection/irritation.

The history and physical from a hospital with the admission date of 11/6/13 revealed the resident was transferred to the hospital for a blood sugar over 600. The staff noted decreased mental status one or two weeks ago but when associated with the elevated blood sugars yesterday they call the ambulance. The note further documented the resident was extremely dehydrated as well as hyperglycemic (a greater than normal amount of glucose in the blood). The resident appeared to be in sepsis (toxic response to an infection) and had numerous metabolic electrolyte disturbances. Is also in respiratory failure although this is not as significant as his/her other issues at this time. The staff will treat with intravenous insulins (used for increased glucose in the blood) and fluids and the resident was admitted to the intensive care unit.

The patient's discharge referral dated 11/13/13 revealed orders for tube feedings of 2 calorie HN at 45 ml per hour for 21 hours daily. Hold the tube feeding 1 hour before and 2 hours after each Dilantin (medication used to treat seizures) dose and water flushes of 200 ml every 4 hours.

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Prior to discharge from the hospital on 11/13/13 the resident's sodium level was 141 millimoles per liter (mmol/L) with the normal range of 136-145 mmol/L, potassium level was 4.4 mmol/L with the normal range of 3.6 to 4.9 mmol/L , and the blood urea nitrogen (BUN) level was 10 milligrams/deciliter (mg/dl) with the normal range of 6-20 mg/dl .

The Treatment Administration Record beginning on 11/14/13 listed the order to flush the peg tube with 200 ml of water every 4 hours. Staff documented they had given the flushes as ordered.

The Medication Administration Record beginning on 11/14/13 listed the order for 2 calorie HN at 45 ml per hour for 21 hours per day, 4 times daily, with the schedule of 6:00 A.M. to 10 A.M., 10 A.M. to 2:00 P.M., 2 P.M. to 6 P.M., and 6 P.M. to 12 A.M. Consisting of 18 hours of the tube feeding instead of the physician ordered 21 hours.

Administrative nurse A on 12/5/13 at 4:29 P.M. stated the resident received his/her Dilantin dose sometime between 6:00 A.M. and 10 A.M. The staff held the tube feeding for 1 hour prior to and 2 hours after the Dilantin dose. He/she stated the varied time period was based on when staff placed the tube feeding on hold. Administrative nurse A stated the schedule time frames of 6:00 A.M. to 10 A.M., 10 A.M. to 2:00 P.M., 2 P.M. to 6 P.M., and 6 P.M. to 12 A.M. were just the times the nurse signed the feeding was infusing, even though they turn the feeding off for 3 hours between the 6:00 A.M. to 10:00 A.M. period. He/she was unable to explain why the staff did not document the feeding from 12:00 A.M. to 6:00

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A.M.

Nurse's note dated 11/14/13 at 3:00 P.M. revealed the resident had a temperature of 100.5 degrees Fahrenheit (F) and tylenol was given. Staff did not notify the physician of the increased temperature for this resident that just returned from the hospital.

Nurse's note date 11/14/13 and timed 5:27 A.M. revealed the resident had only received 80 ml of tube feeding and 60 ml of water since return from the hospital at 3:00 A.M. Based on the physician's orders the resident should have received more than 90 ml of the tube feeding and 300 ml of the water flush scheduled at 5:00 A.M.

Nurse's note dated 11/16/13 at 2:15 A.M. revealed the resident ' s axillary temperature of 99.9 degrees. Staff did not notify the physician of the increased temperature.

According to WebMD the axillary temperature was usually 0.5 to 1 degrees lower than an oral temperature.

Nurse's note dated 11/16/13 at 2:07 P.M. revealed the resident ' s axillary temperature was 100.8 degrees F. Staff did not notify the physician of the increased temperature.

Nurse's note dated 11/16/13 at 2:16 P.M. revealed the resident's temperature was 103 degrees F. Staff did not notify the physician of the increased temperature.

Nurse's note dated 11/17/13 at 2:10 A.M. revealed the resident's axillary temperature was 101.7 degrees F. Staff did not notify the

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physician of the increased temperature.

Nurse's note dated 11/17/13 at 4:16 P.M. the resident ' s temperature was 100.6 degrees F at 3:00 P.M. and at 4:16 P.M. the temperature was 99.6 degrees F. Staff did not notify the physician of the increased temperature.

The nurses' notes lacked evidence the facility monitored the resident's temperature from 11/17/13 at 4:16 P.M. until 11/29/13 at 5:11 P.M.

Nurse's note dated 11/29/13 at 5:11 P.M. documented the resident had a low grade fever during days and the resident had became less respondent to stimuli again over the past 2 days. Resident continued with the gasping type breaths, the temperature was 102 degrees F, and staff notified the doctor after another Tylenol dose was given. The physician ordered the facility to transfer the resident to the hospital.

The nurses' notes lacked evidence the facility monitored the resident's temperature from 11/17/13 at 4:16 P.M. until 11/29/13 at 5:11 P.M.

Nurse's note date 11/29/13 at 5:21 P.M. documented the resident left the facility at 3:30 P.M. by ambulance to go to the hospital.

The emergency room note dated 11/29/13 and timed 4:32 P.M. revealed the resident's high sodium level was 177 mmol/L, a high potassium level of 5.3 mmol/L, and the BUN was high at 183 mg/dl. The resident was transferred to the intensive care unit for decreased level of consciousness and severe dehydration.

The nephrology (deals with the diseases of the

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F 309	Continued From page 8 kidney) assessment dated 11/29/13 at 9:39 P.M. included the diagnoses of hypernatremia (increased sodium level in the blood), the resident was roughly 10 liters of free water down this pm, he/she probably had not had water in about 2 weeks. Given his/her high fever, this would increase his/her obligatory of free water losses. On 12/6/13 at 8:55 A.M. the resident laid in the hospital bed with an intravenous solution being administered. The tube feeding was on hold due to medication administration. Administrative nurse B on 12/9/13 at 11:49 A.M. provided information included the staff should notify the physician if the resident's temperature was higher than 101 degrees F. Licensed nurse C on 12/3/13 at 3:15 P.M. stated the facility did not have specific orders as to how much flush the staff should provide. He/she usually provided the amount of flush based on the size of the resident. Administrative licensed staff A on 12/3/13 at 4:20 P.M. stated each resident had specific orders as to the amount of the water flushes. The clinical record lacked evidence the facility conducted timely assessment and notified the physician of the increased temperature and lacked evidence the facility administered the tube feedings as ordered for this resident transferred to the hospital's intensive care unit for severe dehydration for this cognitively impaired dependent resident who received all his/her fluids via the g-tube.	F 309		
F 322	483.25(g)(2) NG TREATMENT/SERVICES -	F 322		

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F 322 SS=D	Continued From page 9 RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: The facility identified a census of 29 residents. Sample size was 3 residents of which 3 were reviewed for gastrostomy tubes. Based on observation, record review, and interview, the facility failed to provide care of the feeding tube as ordered for 2 (#4, #2) residents of the sample. Findings included: - Resident #4's quarterly Minimum Data Set 3.0 dated 8/12/13 revealed the resident had severely impaired decision making skills, did not speak, required total assistance with eating, had a	F 322		

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feeding tube, and received 51 percent or more of his/her total calories through the tube feeding.

The Care Area Assessment for feeding tubes, dated 5/24/13 documented the resident received nothing by mouth, and received all his/her fluids via the gastrostomy tube (g-tube - the introduction of a nutrient solution through a surgically inserted tube into the stomach through the abdominal wall). Staff provided oral care per shift and as needed. The resident received 2 cans of Jevity (supplement) three times a day and 1 can at bedtime with water flush of 50 milliliters (ml) pre and post feeding and medications.

The care plan dated 10/22/13 listed the interventions: the doctor and dietitian determined that I should be given Jevity and how it should be given, give my tube feedings according to their orders, I need water in addition to the formula I receive, the dietician and doctor also determined how much water I should have every day, give me water by my feeding tube according to the orders, give my medications through my feeding tube because I cannot swallow them, they will need to be liquids or be crushed, staff need to flush the g-tube with water before each medications was given and after all medications were given, the orders will tell staff how much water to use, and staff should check for proper placement each time they give my medications or formula by checking for residual and auscultation (listening over the abdomen while instilling air into the tube.

The 11/21/13 physician orders listed the order for Jevity 1.2 calories per ml, give 2 cans via the g-tube at 4:00 A.M., 10:00 A.M., and 4:00 P.M., 1 can at 10:00 A.M., and flush with 50 ml of water

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before giving medications and supplements and flush after feeding or medications with 50 mls of water.

The Treatment Administration Record for 11/13 and 12/13 lacked evidence of the water flushes.

On 12/3/13 at 3:10 P.M. licensed nurse C crushed baclofen (muscle relaxant) and placed it in a medication cup, and opened 2 tablets of balsalazide disodium (anti-inflammatory) and placed them in the same medication cup. Licensed nurse C attached a syringe to the g-tube and without checking the placement of the g-tube poured an unmeasured amount of water into the syringe, poured the dry medications into the syringe, followed with an unmeasured amount of water 4 times into the tube and then attached the feeding bag with the Jevity to the g-tube.

Licensed nurse C stated on 12/3/13 at 3:15 P.M. he/she flushed the g-tube with 200 ml of water and the facility did not have specific orders as to how much water flush the staff should provide. He/she usually provided the amount of flush based on the size of the resident. He/she also stated the staff should check the placement of the g-tube prior to the administration of medications, flushes, or tube feedings.

Administrative licensed staff A on 12/3/13 at 4:10 P.M. stated the staff that entered the flush orders, mistakenly placed them as a continuous order on the Treatment Administration Record so the staff would not document they gave the flushes.

Administrative licensed staff A on 12/3/13 at 4:20 P.M. stated the nurses should mix the medications with water, staff should not give the

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medications dry into the g-tube. Staff should flush before and after giving the medications and each resident had specific orders as to the amount of the water flushes. Staff should check placement of the g-tube by auscultation or aspiration, and if staff received more than 50 percent from the previous feeding, staff should hold the feeding and notify the physician.

The facility provided undated policy for Gastrostomy Tubes - Administering Medications, listed the interventions: verify placement of the tube by attaching a catheter tip syringe with 10 to 15 ml of air and auscultate with the stethoscope over the abdomen while injecting air, check for gastric residual and note amount, if any, flush tube with 15 to 30 mls of warm water, follow other parameters if ordered by the physician, each medication must be diluted and administered individually unless staff received other orders, dilute each crushed medication in 5 mls of water, unless specific orders were received, if administering more than one medication, flush with 5 to 10 mls of water between medications, and flush the tube with 30 ml of water after the last medication begins to drain from the tubing, or follow other parameters if ordered by the physician,

The facility failed to check placement of the g-tube prior to administration of medication, failed to dilute and individually administer the medications, and failed to follow the physician ' s orders for the water flushes. The clinical record lacked evidence the staff administered the physician ordered water flushes.

- Resident #2's quarterly Minimum Data Set 3.0 dated 9/24/13 revealed a Brief Interview for

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Mental Status score of 14 indicating intact cognition. The resident required extensive assistance with eating, had a feeding tube, and received 51 percent or more of his/her calories through the feeding tube.

The Care Area Assessment for feeding tubes dated 3/18/13 documented the resident depended on the percutaneous endoscopic gastrostomy (peg) tube (the introduction of a nutrient solution through a surgically inserted tube into the stomach through the abdominal wall) for all nutritional intake. The resident was a high aspiration risk secondary to the effects of his/her multiple sclerosis (progressive disease of the nerve fibers of the brain and spinal cord).

The revised care plan dated 11/6/13 listed the interventions: administer the tube feeding with water flushes per the physician ' s orders, the dietitian and doctor had determined how much water the resident should have every day and staff should give the water according to their order, give medications through the feeding tube and flush the tube with water before each medication was given and after all medications were given, the orders would tell staff how much water to use, and check for proper placement each time staff administered medications or formula by checking for residual and auscultating.

The 11/12/13 physician's orders listed: Jevity (supplement) 1.2 calories/milliliters (ml) 2 cans at 9:00 A.M.. and 9:00 P.M. and 1 can at 1:00 P.M. The 10/8/13 physician order listed the order to flush the peg tube with 30 ml of water before giving medication, after the medication was administered, and after the formula was given, and check peg placement before administering

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175346	A. BUILDING _____ B. WING _____	C 12/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMA MANOR	234 MANOR CIRCLE ALMA, KS 66401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 322	Continued From page 14	F 322		

any fluids or medications.

On 12/23/13 at 3:00 P.M. licensed nurse C crushed Zanaflex (muscle relaxant), baclofen an (muscle relaxant), and cluturelle (used for digestive functioning) and placed them in the same medication cup. Licensed nurse C attached the syringe to the resident ' s peg tube and without checking placement poured approximately 2 ounces of cranberry juice and half of the crushed medications into the syringe, allowed it to drain into the tube and then placed 2 more ounces of cranberry juice into the syringe followed by the rest of the dry medications, and then followed with an unmeasured amount of water.

Licensed nurse C on 12/3/13 at 3:15 P.M. stated the facility did not have specific orders as to how much flush the staff should provide. He/she usually provided the amount of flush based on the size of the resident. He/she also stated the staff should check the placement of the g-tube prior to the administration of medications, flushes, or tube feedings.

Administrative licensed staff A on 12/3/13 at 4:20 P.M. stated the nurses should mix the medications with water, staff should not give the medications dry into the g-tube. Staff should flush before and after giving the medications and each resident had specific orders as to the amount of the water flushes. Staff should check placement of the g-tube by auscultation or aspiration, and if staff received more than 50 percent from the previous feeding, staff should hold the feeding and notify the physician.

The facility provided undated policy for

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F 322	Continued From page 15 Gastrostomy Tubes - Administering Medications listed the interventions: verify placement of the tube by attaching a catheter tip syringe with 10 to 15 ml of air and auscultate with the stethoscope over the abdomen while injecting air, check for gastric residual and note amount, if any, flush tube with 15 to 30 mls of warm water, follow other parameters if ordered by the physician, each medication must be diluted and administered individually unless staff received other orders, dilute each crushed medication in 5 mls of water, unless specific orders were received, if administering more than one medication, flush with 5 to 10 mls of water between medications, and flush the tube with 30 ml of water after the last medication begins to drain from the tubing, or follow other parameters if ordered by the physician. The facility failed to check placement of the g-tube prior to administration of medication, failed to dilute and individually administer the medications, and failed to follow the physician's orders for the water flushes.	F 322		